DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155205		(X2) MI A. BUII		ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  12/08/2011		
		155295	B. WIN			12/08/2	U11 
NAME OF PROVIDER		AND REHAB CENTER		809 W F	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041		
`	ACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0000		,					
Surve 2011 Facili Provid AIM: Surve Toni I Tamn DeAn Censu SNF/I Total: Censu Media Media Other Total: Samp Suppl These findin 16.2.	ty number: der number: 10  ty team: Maley, BSV ny Alley, R nn Mankell, ns bed type: NF: 73  rs payor type care: 10 caid: 52  rs 11 rs 73  le: 15 emental san e deficiencie ags cited in	000192 : 155295 00291120 W, TC N RN		000	This Plan of Correction is the center'scredible allegation of compliance. Preparation and/execution of this plan ofcorredoes not constitute admission oragreement by the provider the truth of thefacts alleged of conclusions set forth in the statement of deficiencies. plan ofcorrection is prepared and/or executed solely because is required by the provisions offederal and state law.	for oction n of or The	(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RLTV11

Facility ID:

000192

If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		(X2) MULTIPLE C  A. BUILDING  B. WING	00	(X3) DATE COMPI 12/08/2	ETED		
	ROVIDER OR SUPPLIER	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN46041				
(X4) ID PREFIX TAG  F0151 SS=D	SUMMARY STATE (EACH DEFICIENCE REGULATORY OR PREGULATORY OR Quality review 1: Williams, RN  The resident has the rights as a resident the rights as a resident or resident. The resident has the interference, coerciveries all from the father rights. Based on observation review, the residents were gittheir room window reviewed for chook (Resident # 53 and Findings include)  During the group 2 p.m., Resident not open her room had been "locked open even a "small p.m., the window would not make the process of the pro	catement of deficiencies cy Must be perceded by full Lsc identifying information)  2/14/11 by Suzanne  the right to exercise his or ident of the facility and as a of the United States.  the right to be free of cion, discrimination, and acility in exercising his or action, interview and the facility failed to ensure even the choice to open tows for 2 of 14 residents ices in a sample of 15. and 54)  interview on 12/6/11 at # 53 indicated she could the windows because they are and they would not all bit."  commental tour on 12/7/11 andow in Resident # 53's and to have 2 screws arable window so the ot open. At that time the Maintenance defined the instructed the same are also as a simple of the core of the co	FRAN  ID  PREFIX  TAG  F0151	I.  Residents that were affected by the alledeficient practice and megative outcome been identified.  II.  Residents that were affected by the alledeficient practice in the protection of the p	e ged ave o nas	(X5) COMPLETION DATE  01/07/2012	
		dows so they would not ed the residents residing		done a house wide			

000192

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155295	A. BUII	LDING	00	COMPLETED 12/08/2011
		130293	B. WIN		DDDEGG CITY CTATE ZID CODE	12/00/2011
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST	
CLINTON	N HOUSE HEALTH	AND REHAB CENTER			FORT, IN46041	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
-	in this room had	the windows opened by		-	audit and no other	
	the CNAs, and the open windows made the hallway and other room too hot and			windows have been		
		ing would freeze up. He			identified to have an	N/
		been asked to speak at a				
		l meeting regarding this a			issues with opening,	
	_	He also indicated no			with the exception o	f
		om windows were			the secured memory	<i>'</i>
	screwed shut.				care unit.	
	On 12/7/11 at 3::	30 p.m., during interview,			III. Staff ha	ve
		dicated that if she could			been re-educated or	1
		about her room, it would			residents rights.	
		She indicated the olted shut. She indicated			Maintenance or	
		re open because the air				
		ner room was not working			designee will audit a	II
		fall. She indicated the			windows one time a	
	Administrator w				week for one month	,
		ner room was not dicated she did not know			and then monthly fo	r
	_	re bolted until she had			four months. Staff	
		open the window and			non-compliance will	
		lted" shut. She also			be addressed with 1	:1
	by herself.	ald not go outside for air			education and	
					progressive	
		55 p.m., during interview,				
		dicated this past summer			disciplinary action as	5
		ing in her room was not			deemed.	
	working and her and her roommate opened their room windows. She				IV. Results v	will
	indicated she had				be reviewed monthly	y
		She also indicated she did				,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVE	EY	
AND PLAN	OF CORRECTION	155295		ILDING	00	COMPLETED 12/08/2011	
		100200	B. WII		DDDEGG CHTV CT TT	12/00/2011	
NAME OF I	PROVIDER OR SUPPLIER	<b>t</b>		1	DDRESS, CITY, STATE, ZIP CODE		
		AND REHAB CENTER			FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	PLETION DATE
1710		ndows were locked until	+		· · · · · · · · · · · · · · · · · · ·		
		er roommate, had told			in QA meeting for 6		
	· · · · · · · · · · · · · · · · · · ·	ed she had asked the			months and the		
		unlock the windows and			quarterly with		
	he informed her because it would	that it could not be done			subsequent plan		
		ne indicated there was not			development and		
	_	n her regarding screwing			implementation as		
		or any other options			appropriate.		
		e windows being screwed			- lake, ake, 1960.		
	shut.						
	During the daily	exit on 12/7/11 at 4:30					
	1	rview, the Administrator					
	1	October 2011 the reasons					
	for screwing the	window shut had been					
		he Resident Council. He					
		ndows being open in that					
	_	blems with the air					
	_	l with allergies for other					
		dicated he had no of any discussion with the					
		regarding screwing the					
		offering other solutions					
	to the above state	· ·					
		•					
		dent Council meeting					
		dicated "Windows					
		(and) residents can't open					
		The note also indicated					
	1	ested maintenance to					
		mber 30 meeting to					
		Resident # 54 was in					
	attendance.						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	RLTV11	Facility I	D: 000192 If continuation s	heet Page 4 o	of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			X2) MUI	LTIPLE CO	NSTRUCTION		(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155295	P	A. BUILD	DING	00		12/08/2	
		100280		B. WING				12/00/2	011
NAME OF F	ROVIDER OR SUPPLIER	₹				DDRESS, CITY, STA	ATE, ZIP CODE		
CLINITON		AND REHAB CENTER				REEMAN ST FORT, IN46041			
						-OK1, IN40041			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		D.	ID REFIX		PLAN OF CORRECTION /E ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		r.	TAG	CROSS-REFERENCE	ED TO THE APPROPRIATICIENCY)	E	DATE
1710	REGUESTIONT ON	ESC ISSIVIII TING IN GRAINTIO	')		1110				DITTE
	A 11/30/11 Resid	dent council meeting							
		dicated concerns from the							
		g were addressed. The							
	-	nd Maintenance Director							
		ce in the meeting and							
		issues. Resident # 54 was							
	in attendance.	issues. Resident π 57 was							
	in attendance.								
	A "Resnonse to 1	Resident Council							
	•	nber 15th, 2011 Meeting							
		Windows screwed shut							
		n't open for fresh air. a.							
		ultiple reasons for not							
		en the windows. i. In the							
		e air condition units are							
		en there are open windows							
	-	umidity comes in the							
	-	nto the air handling units							
	in the attic and fi								
		esident enjoys the outside							
	_	ree to five other resident							
	•	ly of having the air							
		ilii This facility is a							
		ty, not a residential							
		1-21-11, we have 71							
		rcent of these resident							
	have a diagnosis								
	_	outside dust and pollen is							
		acility environment it							
	-	ances of these residents							
		eing placed in distressiii							
	_	vides year round access for	.						
	residents to get f	-							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID	: RL1	ΓV11	Facility II	D: 000192	If continuation sh	neet Pag	ge 5 of 54

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MU A. BUIL B. WING	DING	onstruction 00	(X3) DATE S COMPL 12/08/20	ETED	
	PROVIDER OR SUPPLIER	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  809 W FREEMAN ST FRANKFORT, IN46041					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
F0241 SS=D	SecurityEven in several years, our access form wind open"  A policy titled "Naights" was proved Administrator on and deemed as cuindicated: "Basic right to be treated in recognition of preferencesLive Care Express presure your room and room in writing before made"  3.1-3(t) 3.1-3(u)(3)  The facility must paramaner and in a maintains or enhance and respect in full individuality.  Based on observative record review, the dependent resident to maintain or entared.	Nursing Home Resident rided by the 12/5/11 at 10:50 a.m., arrent. The policy Rights You have the d with respect and dignity your individuality and ing Accommodations and ferences with respect to sommate and be advised	F0	241	I. Reside		01/07/2012	
	_	ing in a sample of 15			by nursing and found to have no adverse effects from alleged			
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: F	RLTV11	Facility l	ID: 000192 If continuation sl	neet Pac	ge 6 of 54	

RLTV11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155295 12/08/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE HEALTH AND REHAB CENTER FRANKFORT, IN46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE deficient practice. Resident #74's record was reviewed on II. Residents 12/5/11 at 3:37 p.m. who have assistance Resident #74's current diagnoses included, during meal time have but were not limited, Alzheimer's disease the potential to be and anxiety. affected by the alleged Resident #74 had a current, 11/8/11, deficient practice. annual, Minimum Data Set assessment Nurse aide #6 has (MDS) which indicated the resident required staff assistance in order to eat. been re-educated on customer service, Resident #74 had a current, 3/4/11, care plan problem/need regarding nutritional Vocollect charting, risk. Approaches to this problem resident rights, and included, but were not limited to, proper feeding encourage to consume 75% of meals; allow ample time to consume meals. techniques. Nursing staff as been During a 12/5/11, 11:40 a.m. to 12:35 p.m., lunch meal observation, CNA #6 fed re-educated on the Resident #74 her meal. While feeding above same. Resident #74, the CNA did not speak to DON or III. her, identify the food items, ask the resident to eat, make conversation or designee will monitor praise the consumption of food. CNA #6 meal times on random spoke into her headset the entire meal. shifts five times a The CNA did not speak and instead tapped the spoon on the resident's lip to week for one month, 3 encourage the resident to eat. Examples times a week for one of statements spoken by CNA #6 month, once a week included, but were not limited to, "select room 718 bed one, go back, cancel, select

000192

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUIL	L. BUILDING 00 COM		(X3) DATE COMPL 12/08/2	MPLETED	
	PROVIDER OR SUPPLIER	AND REHAB CENTER		809 W F	DDRESS, CITY, STATE, ZIP CODE REEMAN ST FORT, IN46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	room 715,yes75, 240bed 2	50, 240, select room,			for one month and monthly for 3 month	S.	
	LPN #7 indicated spoken to the res Resident #74 to continue to the res Resident #74 to continue the Director of National Support The Director of National Theorem T	1, 12:35 p.m., interview, d CNA #6 should have ident and encouraged dine. The CNA should inversing with the alked with the resident.  ent, facility policy titled, which was provided by tursing on 12/8/11 at ated the following: resident feel that a meal but that the procedure is im/her your complete			Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed. IV. Results was be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as	:h vill	
F0252 SS=C	comfortable and hallowing the reside personal belonging Based on observation facility failed to clean and in good cracked, and peedirty floors, vental shower rooms. To	rovide a safe, clean, omelike environment, ent to use his or her gs to the extent possible. Action and interview, the ensure the facility was d repair related to torn, ling drywall and paint, s, toilets, windows, and This deficit practice had effect 73 of 73 residents	F0	252	appropriate.  I. No residents were identified to be affected by this		01/07/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155295	B. WIN			12/08/2011
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST	
CLINTO	N HOUSE HEALTH	AND REHAB CENTER			FORT, IN46041	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	who reside in the building.				alleged deficient	
	Findings include:				practice.	
					II. All	
	_	onmental tour on			residents have the	
		n., with the Maintenance Environmental Services			potential to be	
		owing was observed.			affected by this	
	200 and 400 Ha	Ukrossa			alleged deficient	
	200 and 400 Ha	nway.			practice. All areas	
	The window at the end of the 200 hall had				identified have beer	1
	cob webs in the	window sills.			assessed and cleane	d
	The floor in the	corner at the fire doors on			or repaired by the	
	the 200 and 400	halls had a gray			housekeeping and	
	accumulation of	dust and dirt.			maintenance staff.	
	The 400 hall sho	wer room's baseboard			III.	
	trim hand chippe	ed paint and wood on the			Maintenance and	
	right and left wa	11.				
	The 200 hall sho	wer room first shower			Housekeeping will	
		floor had an orange			audit the building ar	na
	discoloration and	d the grout was dark			grounds randomly	
	brown to black to	hroughout.			three times a week t	for
	Room 209's toile	et had a brown build up of			one month, once a	
		ne base. The window sills			week for 3 months a	ind
	had cob webs in	the corner.			monthly for 2 month	ns
	Room 417's bathroom doors on the inside				to ensure proper	
	were scratched with chipped wood 1/3 of				cleaning and	
	the way up the d	oors.				

000192

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	LETED
		155295	B. WIN			12/08/2	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIEF				FREEMAN ST		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		FRANK	FORT, IN46041		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	500 and 600 Ha	and 600 Hallway			maintenance		
	300 and 000 11a	iiway			techniques have bee	en	
	The floor in the corner at the fire doors on the 500 and 600 halls had a gray accumulation of dust and dirt.				established. Staff		
					non-compliance will		
	accumulation of	and the the			be addressed with 1	:1	
	The 500 hall shower room had a privacy curtain that was off the 3 hooks at the				education and		
		3 ceiling vents had a			progressive		
	build up of dust. The privacy wall around the toilet had areas of broken plaster and				disciplinary action a	S	
					deemed.		
	paint 1/4 way up	the wall.			IV. Results	will	
	In the main dini	ng room, 5 of 15 ceiling			be reviewed in QA		
		d visible cob webs and all			•		
		aild up of dust. The floor			meeting monthly x 6	5	
		by the fireplace had dust			months and then		
	and cob webs.	oy the mephase had dust			quarterly with		
					subsequent plan		
		orn and peeling paint			· · ·		
	under the heating	g unit.			development and		
	700 Hall				implementation as		
	/UU Hall				appropriate.		
	The 700 hall sho	ower room entry door had			,		
		ken wood from latch to					
		er stalls had a build up of					
		ince on the tiles around					
	the walls and darkened grout.						
	The floor in the corner at the fire door on						
	the 700 hall had a gray accumulation of						
	dust and dirt.						

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	PROVIDER OR SUPPLIER	AND REHAB CENTER	809 W	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST KFORT, IN46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	cracked plaster, t room 711 had an The dining room	de room 710 and 711 had he ceiling vent outside accumulation of dust. had debris scattered on aghout. The table under			
	the television had dust.	l an accumulation of			
	bed's nightstand	nipped paint by the 1st and the floor around the n soiling. The window			
	_	he Maintenance ated during interview, he on the needed repairs.			
	3.1-19(f)				
F0282 SS=E	facility must be pro in accordance with plan of care.	ded or arranged by the ovided by qualified persons a each resident's written			
	interview, the factory physician orders oxygen administration of a pressure ulcereviewed for follows:	review, observation and cility failed to ensure the were followed regarding ration and the treatment ers for 4 of 15 residents owing physician orders 4. (Resident # 6, 28, 43)	F0282	I. Residents # 6, 28, 43 and 47 have been assessed by nursing and no adverse affect	01/07/2012 ts

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		155295	B. WIN			12/08/2011
NAME OF I	PROVIDER OR SUPPLIER	₹		1	ADDRESS, CITY, STATE, ZIP CODE	
CLINTO	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
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	F' 1' ' 1 1				have been identified	
	Findings include:				by this alleged	
	1. The record for	or Resident # 6 was			deficient practice.	
		5/11 at 3:30 p.m.			II. Reside	ents
	limited to, Chron	es included, but were not			with physician orders	S
	Pulmonary Dise				for oxygen	
		1 0 0 1			administration or ski	n
	Current physician orders for December 2011 indicated an order for oxygen to be				treatments have the	
	administered at 2 liters daily.				potential to be	
	0 10/5/11 110	D 11 4/16			affected by the allege	ed
		2 p.m., Resident # 6 was r in the hallway; his			deficient practice.	
	oxygen rate was				"Check for 02 rates",	
					and "check for	
	_	e resident was in his s room; his oxygen rate				
	was set at 2.5 lite				placement of	
					dressing" have been	
	-	PN # 2 was informed the			added to the	
		at the incorrect rate. At sinterview, she indicated			MAR/TAR to prompt	
	, ,	ald be on 2 liters of			nursing to verify and	
		changed to flow rate to 2			check placement.	
	liters.				Nursing staff have	
	2. The record for	or Resident # 28 was			been re-educated on	
	reviewed on 12/	6/11 at 9:35 a.m.			administration of	
					treatment and	
	Current diagnoses included, but were not limited to, Chronic Obstructive				physicians orders.	
	Pulmonary Dise				F.1751514113 5146131	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295		LDING	NSTRUCTION  00	(X3) DATE COMPI 12/08/2	ETED	
	PROVIDER OR SUPPLIER	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN46041					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	2011 indicated a administered to a greater than 90 %  On 12/5/11 at 5:: in her wheelchai oxygen rate was time, LPN # 3 ch	n orders for December n order for oxygen to be maintain saturations and to keep at 2 liters.  30 p.m., the resident was r in the dining room. Her set at 1.5 liters. At that necked the flow rate and interview, indicated the be set at 2 liters.			III. DON or designee will monitor O2 rates and placement of dressing on random shifts 3 times a week for one month, once a week for two months, once a month for three months. Staff non-compliance will be addressed with 1 education and progressive disciplinary actions a deemed.  IV. Results where the reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as	ngs e e		

NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  SIGNATE ADDRESS, CITY, STATE, ZIP CODE:  SON W FREEMAN ST FRANKFORT, IN46041  SIMMARY STATIMENT OF DIRECTION IS  BEGULATORY OR I.SC IDENTIFYING INFORMATION)  3. During the facility tour on 12/05/2011  at 10:08 A.M., Resident #47 was identified by I.PN #1 as having no pressure ulcers.  Resident #47 was observed on 12/07/2011  at 10:00 A.M., with I.PN #1. His occyx was observed. He had a 0.6 cm x 0.2 cm reddened ulcer on his left buttock. There was no dressing on the ulcer. I.PN #1 touched the reddened the resident said "Ouch." I.PN #1 indicated he had a treatment of Xenaderm only. She further said his coccyx "didn't look like that yesterday."  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Resident #47 clinical record was reviewed on 12/05/2011 at 10:50 A.M.  Review of the December 2011 physician's orders indicated an order for "Vasolex ointment i.e Xenaderm ointment. Apply to cocyx, cw (cover with) Mepilex, change twice daily and as needed."	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
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(treatment administration record)								
		(treatment admir	nistration record)					

000192

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2)	MULTIPLE CO	ONSTRUCTION		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	MBER:	A. B	UILDING	00		COMPL	
		155295		B. W	ING			12/08/2	011
NAME OF E	PROVIDER OR SUPPLIE	P.		•	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
NAME OF I	NO VIDER OR SOLITEIE	IC.				FREEMAN ST			
CLINTON	N HOUSE HEALTH	AND REHAB CEN	ITER		FRANK	FORT, IN4604	1		
(X4) ID	SUMMARY S	STATEMENT OF DEFICI	ENCIES		ID	PROVIDER'S	PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDE			PREFIX	CROSS-REFERENC	IVE ACTION SHOULD BE CED TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INF		_	TAG	DE	EFICIENCY)		DATE
		er for "Vasolex oi							
	then Xenaderm	to coccyx BID et 1	prn						
	soilage" had bee	en completed as or	dered.						
	On 12/07/2011 a	at 10:05 A.M., the	DON						
	indicated "Yes,	there should have	been a						
	dressing on his o	eoccyx."							
	4. During the fa	cility tour on 12/0	05/2011						
	at 10:05 A.M., F	Resident #43 was							
	identified by LP	N #1 as using oxy	gen.						
		2 3							
	Resident #43's v	vas observed on							
		5 A.M. She had o	oxvgen						
		asal cannula. The							
	_	#1 observed the s							
		3 should have her							
		changed the oxyg	en						
	setting to 2 L.								
	Dagidant #42la a	linical record was							
	reviewed on 12/	06/2011 at 1:15 P	.M.						
		liagnoses included							
	· ·	D (chronic obstruc	ctive						
	pulmonary disea	* *							
		oronary heart disea							
		are with an interna	ıl						
	fixation.								
	The resident's D	ecember 2011 phy	ysician's						
	orders indicated the resident had an order								
	originally dated 10/21/2011 for "Oxygen								
		C (nasal cannula).							
FORM CMS-2	2567(02-99) Previous Versi		Event ID:	RLTV1	1 Facility	ID: 000192	If continuation sh	eet Par	ge 15 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  00	(X3) DATE COMPI 12/08/2	LETED
	ROVIDER OR SUPPLIER	AND REHAB CENTER	809	EET ADDRESS, CITY, STATE, ZIP ( W FREEMAN ST ANKFORT, IN46041	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F0314 SS=D	a resident, the factoresident who enterpressure sores do sores unless the indemonstrates that a resident having precessary treatments from develoting prevent insores from develoting. Based on observation interview, the factorist with precession to ensure a treatment of the sample of 15 (Ref. #47).  Findings include  1. During the factorist at 10:05 A.M., Resident #43 was heel flat on the bottop of the right for Resident #43's heel flat on the bottop of the right for Residen	ation, record review, and cility failed to prevent are ulcers for 1 of 3 essure ulcers and failed ment was in place for 2 of a pressure ulcers in esidents #18, #43 and d:	F0314	I. Residents # 18, 4: have been assessed nursing staff and no affects have been id this alleged deficient Residents with a dia open areas or press have the potential to by this alleged defici A review of current in residents' medical rehas treatment orders completed to identify treatments and skin assessments. Physic notified if applicable, staff have been refacility expectations physicians' orders, a treatments, document pressure ulcer prevent DON or designee with treatment and placed dressings on randon times a week for one a week for two mont month for three monnon-compliance will	d by the adverse lentified by the practice. II. gnosis of ure wounds to be affected lent practice. In house ecord, that is has been any any missing ducated on of following administering intation and lention. Ill monitor ment of in shifts 3 is month, once this, once a lentified.	01/07/2012

000192

155295	BUILDING 00 VING	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN46041	•
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPROPRIES OF THE CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIES OF THE CROSS-REFERENCED TO THE APPROPRIES OF THE A	E COMPLETION
had a 6.0 cm. (centimeter) by 6.0 cm. dried black rounded area. The left heel had a 1.5 cm circular area on the inner aspect of the heel.  Resident #43 was observed lying in her bed on 12/7/2011 at 3:00 P.M. Her heels were flat on the bed. There was a pillow under her knees.  Resident #43's clinical record was reviewed on 12/06/2011 at 1:15 P.M.  Resident #43's diagnoses included, but not limited to, COPD (chronic obstructive pulmonary disease),, depression, hypertension, coronary heart disease, and a right hip fracture with an internal fixation.  Resident #43 was readmitted to the facility on 10/20/2011 at 6:30 P.M., post right hip fracture. Her readmission assessment indicated clear, intact skin on the resident's heels.  The change of condition report for skin condition dated 11/1/11 at 2:00 P.M., indicated 3 areas of new onset of wounds located on "(R) inner heel 6 x 9 cm. blood filled intact blister, (L) outer heel 1.6 x 2.0 fluid filled c (with) 3 x 6 fluid filler c 3 x 6 surrounding, top of (R) foot 1 x 1.5 dark redness area c 5.0 x 9.0 redness	with 1:1 education and progressive disciplinary as deemed. IV. Results will be reviewed in QA meeting	tion as e onthly erly

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				NSTRUCTION 00	(X3) DATE : COMPL		
		155295	A. BUI B. WIN	LDING IG		12/08/2	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
		AND REHAB CENTER			FREEMAN ST FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e problem was an acute hich was from pressure					
		nere was a notation at					
	3:30 P.M. of "	These areas were not					
	present yesterday	y"					
	The nurses' notes	s indicated on 11/1/11 at					
		listers to (L) (left) (R)					
	(right) heels et to						
	•	e skin condition report dicated a friction blister					
		the resident's right inner					
		cm by 9.0 cm with an					
		pth. The description was					
	1	led blister." The					
		n 12/1/2011 were 6.0 cm.					
	1 -	s described as black, ith no change. There was					
	no drainage.	itti ilo change. There was					
		er evaluation record dated					
		d a friction blister had					
	It was 1.6 cm by	resident's left outer heel.					
	1	pth. The description was					
		ry" but unable to					
		pth. The measurements					
	on 12/1/2011 we	re 1.5 cm. by 1.5 cm.					
	Review of the D	ecember 2011 physician's					
		an order for "Float heels					
	off bed."						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		ĺ	LDING	NSTRUCTION  00	(X3) DATE COMPL 12/08/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					FREEMAN ST		
		AND REHAB CENTER		l	FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES  CV MUST BE PERCEDED BY FULL		ID PREEIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
PREFIX TAG	Review of the Do Administration F for "Float heels of indicated this tree completed each is 12/1/11-12/7/11.  Review of the Ro MDS (minimum dated 9/19/2011, needed extensive to move in bed. as having no present the resident's clical assessment. As of facility none was review of the resident preventing aired skin intimpaired mobility interventions incollimited to, "press	ecember TAR (Treatment Record) indicated an order off bed." The TAR atment had been shift on the dates of esident #43's quarterly data set) assessment, indicated the resident e assistance of one person She was further assessed source ulcers.  mical record lacked a skin of the exit from the a provided by the facility.  sident's care plan plan for "Skin integrity intion" for the Potential for regrity r/t (related to) y dated 10/29/2011. The luded, but were not sure reducing mattress,		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION DATE
		osition as able" The dated on 11/5/11 with a					
		I filled sac (sic) bilat					
		' and on 11/6/11, "eschar					
	· ·	were no further updates					
	to the care plan.						
	_	iew with LPN #1 on A.M., she indicated the					

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	PROVIDER OR SUPPLIER	155295	A. BUILDING B. WING		12/08/2011
					12/00/2011
CLINTON	N HOUSE HEALTH A			ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST	
02	CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			FORT, IN46041	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	resident's black h shearing.	eels had occurred due to			
	at 10:08 A.M., R	eility tour on 12/05/2011 esident #47 was N #1 as having no			
	at 10:00 A.M., w was observed. H reddened ulcer or was no dressing of touched the redde "Ouch." LPN #1 treatment of Xen.	s observed on 12/07/2011 ith LPN #1. His coccyx he had a 0.6 cm x 0.2 cm in his left buttock. There on the ulcer. LPN #1 ened the resident said indicated he had a aderm only. She further didn't look like that			
	Resident #47 clin on 12/05/2011 at	nical record was reviewed 10:50 A.M.			
	Resident#47's diagnoses included, but were not limited to, Bi-Polar, chronic back pain, depression, confusion, and altered mental state.				
	Assessment" date the resident was a pressure ulcer to 2.0 cm (centimete	Jursing Admission ed 11/22/2011 indicated admitted with a stage II the coccyx measuring er) x 1.8 cm.			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155295	B. WIN			12/08/2	011
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	_	k indicated on 11/23/2011					
	the resident had a total score of 9. The key for the scale indicated a "Total score						
	1 -	resents HIGH RISK. This					
	_	12/07/2011 with a total					
	score of 12.	12/0//2011 with a total					
	50010 01 12.						
	Review of the pl	nysician's orders indicated					
	-	1/23/2011 "Xenderm (a					
		for the treatment of					
	_	on coccyx BID (2 times a					
	1 *	Mepilex (a dressing) BID					
	and prn (as need						
		,					
	Review of the N	ovember 2011 TAR					
	(treatment admir	nistration record)					
	indicated an orde	er for "Apply to coccyx:					
	Xenderm et cove	er c/ Mepilex BID and prn					
	soilage" had bee	n completed as ordered.					
		ecember 2011 physician's					
		an order for "Vasolex					
		enaderm ointment. Apply					
		cover with) Mepilex,					
	change twice dai	ily and as needed."					
	Review of the D	ecember 2011 TAR					
	(treatment admir	nistration record)					
	indicated an orde	er for "Vasolex ointment					
	then Xenderm to coccyx BID et prn						
	soilage" had bee	n completed as ordered.					
	_	r pressure ulcers dated					
	11/23/2011 for t	he problem of "Actual					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE : COMPL 12/08/2	ETED	
		155295	B. WIN			12/08/2	011
NAME OF PROVIDE	ER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CLINTON HOUS	SE HEALTH A	AND REHAB CENTER			FORT, IN46041		
,	EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
inter		n the coccyx indicated an Freatment ordered Teplix."					
(min 12/02 press need	imum data s 2/2011 indic sure ulcers. F	Imission MDS  et) assessment dated ated Resident #47 had no He was assessed as e assistance of two hobility.					
indic	On 12/07/2011 at 10:05 A.M., the DON indicated "Yes, there should have been a dressing on his coccyx."						
		rd had no additional the pressure ulcer.					
indic coccy recor 3. The revie Curre limite	ated there w yx pressure ord. he record for wed on 12/6 ent diagnose	t 10:50 A.M., the DON as no monitoring for the alcer in the clinical  Resident # 18 was /11 at 2 p.m. s included, but were not ble Sclerosis and s.					
indic stage meas	ated on 11/1 II pressure suring 1 cent	r Evaluation Record" 8/11 the resident had a ulcer on her coccyx imeter (cm) by 1 cm. r dated 11/18/11					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
		155295	B. WIN			12/08/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CLINITOR		AND DELIAD CENTED			FREEMAN ST		
		AND REHAB CENTER		<u> </u>	FORT, IN46041		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
	indicated an orde	er for a Duoderm to sacral					
		changed every 3 days and					
	as needed until healed.						
	On 12/5/11 at 4:	45 p.m. during a care					
	observation, the	resident was in bed					
	receiving care.	When she was turned to					
		cyx was observed to have					
	*	and yellow in color. No					
		place on the ulcer. After					
		npleted, CNA # 4 applied					
		to the coccyx area					
	_	er. The resident was then					
	_	en up in her wheelchair					
	and taken to the	dining room for dinner.					
	At 5:50 p.m., LP	N # 5 was informed the					
	•	have a Duoderm on her					
		I the CNA had applied					
	-	ulcer area. At that time,					
		, the LPN indicated the					
	resident should h	nave a Duoderm and she					
	thought the day s	shift nurse had completed					
	this treatment. S	She indicated the CNA					
	should not have	applied at the Calazime					
	over the ulcer.						
		d "Pressure Ulcer,					
		vas provided by the					
		ing on 12/8/11 at 12:48					
	_	l as current. The policy					
		rpose To prevent skin					
		development of pressure					
	soresProcedure	e1. Assess for risk of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		(X2) MU  A. BUILI  B. WING	DING	NSTRUCTION  00		X3) DATE S COMPLE 12/08/20	ETED	
	PROVIDER OR SUPPLIER	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  809 W FREEMAN ST FRANKFORT, IN46041					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	(EACH CORRECTIVE A	TO THE APPROPRIATE	=	(X5) COMPLETION DATE
F0323 SS=E	pressure ulcer de high and low risk care plan to elimit factorsd. Press appropriate supporesident's bed and reducing or relieve necessary11. Pressurfaces to protect a pressure ulcer in nurse is responsible the skin, including color, drainage attreatment provided 3.1-40(a)(1) 3.1-40(a)(2)  The facility must environment remains as is possible receives adequated devices to prevent Based on record interview, the facility with the facility interview, the facility interview.	velopment. a. Identify a residents3. Develop inate or minimize risk ture relief7. Use out surface in the d chair. 8. Use pressure ving devices as position with appropriate et bony prominence'sIf is present, the licensed ble to record condition of ag stage, size, site, depth, and odor as well as the ed"	F03		I.	No		01/07/2012
	injury. This defice potential to affect identified as cognitive.	at the possibility of cit practice had the t 8 of 73 residents who nitively impaired and have about the facility.			residents was identified a by this allegonates deficient properties.	as affected ged		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RLTV11

Facility ID:

000192

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		ĺ	ULTIPLE CO LDING	ONSTRUCTION (X3) DATE SURVEY  00 COMPLETED  12/08/2011			
N. 3 55	DROLUBER OF STATE		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	C.		809 W F	FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		FRANK	FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
-				-	residents have the		
	On 12/8/11 at 1:	40 p.m., the					
	_	rovided a list of 8			potential to be		
		ere cognitively impaired			affected by this		
	and could move	about freely.			alleged deficient		
	_	onmental tour on			practice. An audit of		
	_	n., with the Maintenance			the building has been	า	
		Environmental Services owing was observed.			conducted and any		
	Director the following was observed.				materials that may b	e	
	1	n had a bottle of			of hazard have been		
	Softscrub with B above the sink.	Bleach in the cabinet The bottle had			removed and or		
		humans" written on it.			placed in locked		
		Maintenance Director			enviroment. All staff		
		tscrub and indicated			have been		
	_	, the Softscrub should be ked cabinets provided in				24	
	the room.	tea earmets provided in			re-educated on stori	ıg	
					or locking of		
		500 hall shower room			potentially hazardou	S	
	_	us blue safety razors, 2 vash, 1 can of hair spray			materials.		
		irex disinfectant in the			III. DON or		
		t in the room. The			designee will monito	r	
		ek and a key on the			units and storage		
	cabinet but they were not in use. At that time during interview, the Maintenance director indicated the cabinet should be locked with the lock and key provided.				areas on random shi	f+c	
					3 times a week for or	ne	
					month, once a week		
	_	on 12/8/11 at 9:30 a.m.,			for two months and		
	the Administrato	or indicated hazards					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155295 12/08/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE HEALTH AND REHAB CENTER FRANKFORT, IN46041 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE should not be in unlocked areas. once a month for three months. Staff A material safety data sheet for Virex II was provided by the Administrator on non-compliance will 12/8/11 at 12:50 p.m. and deemed as be addressed with 1:1 current. The sheet indicated "...routes of education and entry Inhalation. Skin contact. Eye contact. Potential Acute Health Effects progressive Eyes Corrosive. May cause permanent disciplinary action as damage including blindness. Skin deemed. Corrosive. May cause permanent damage. Inhalation May cause irritation and IV. Results will corrosive effects to nose, throat and be reviewed in QA respiratory tract. Ingestion Corrosive. May cause burns to mouth, throat, and meeting monthly x 6 stomach...." months and then quarterly with 3.1-45(a)(1)subsequent plan development and implementation as appropriate. Based on a resident's comprehensive F0325 assessment, the facility must ensure that a SS=D resident -(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. 01/07/2012 Based on observation, interview and F0325 record review, the facility failed to ensure,

Facility ID:

NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID  PREFIX  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  a resident who required staff assistance to eat and was nutritionally at risk, was fed adequately by staff and given ample time to eat, and was offered replacements for poor consumption, for 1 of 1 resident reviewed for assistance to dine in a sample of 15 (Resident #74).  Findings include:  STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN46041  ID  PROVIDERS PLAN OF CORRECTION (GACIL CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  II.  Resident #74 has been assessed by nursing and found to have no adverse effects from alleged deficient practice.  II.  Residents	E SURVEY PLETED /2011	i '	00	(X2) MULTIPLE CO A. BUILDING B. WING	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  a resident who required staff assistance to eat and was nutritionally at risk, was fed adequately by staff and given ample time to eat, and was offered replacements for poor consumption, for 1 of 1 resident reviewed for assistance to dine in a sample of 15 (Resident #74).  Findings include:  PREFIX TAG  I. Resident  #74 has been assessed by nursing and found to have no adverse effects from alleged deficient practice.  II. Resident  #75 has been assessed  II. Resident  PREFIX TAG  PROVIDERS PROVIDENT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PROVIDENT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  II. Resident  PREFIX TAG  II. Resident  PREFIX TAG  PROVIDENT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PROVIDENT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  PROVIDENT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  II. Resident  PREFIX TAG  II. Resident  PREFIX TAG  II. Resident  PREFIX TAG  II. Resident  PROVIDENT SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  II. Resident  III. Residents		ST	FREEMAN ST	809 W	AND REHAB CENTER		
eat and was nutritionally at risk, was fed adequately by staff and given ample time to eat, and was offered replacements for poor consumption, for 1 of 1 resident reviewed for assistance to dine in a sample of 15 (Resident #74).  Findings include:  #74 has been assessed by nursing and found to have no adverse effects from alleged deficient practice.  II. Resident	(X5) COMPLETION DATE	RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PREFIX	Y MUST BE PERCEDED BY FULL	PREFIX (EACH DEFICIEN	PREFIX
Resident #74's record was reviewed on 12/5/11 at 3:37 p.m. Resident #74's current diagnoses included, but were not limited, Alzheimer's disease and anxiety.  Resident #74 had a current, 11/8/11, annual, Minimum Data Set assessment (MDS) which indicated the resident required staff assistance in order to eat.  Resident #74 had a current, 3/4/11, care plan problem/need regarding nutritional risk due to Alzheimer's disease and the inability to self feed. Approaches to this problem included, but were not limited to, encourage to consume 75% of meals; allow ample time to consume meals.  During a 12/5/11, 11:40 a.m. to 12:35 p.m., lunch meal observation, CNA #6 fed Resident #74, the CNA did not speak to her, identify the food items, asks the		as been assessed sing and found e no adverse from alleged ent practice.  Residents ave assistance meal time have etential to be ed by the alleged ent practice.  aide #6 has re-educated on mer service, ect charting, nt rights and reeding ques. Nursing s been acated on the same.  DON or	#74 has been by nursing and to have no and effects from deficient practil.  who have as during meal the potential affected by the deficient practice with the defi		ionally at risk, was fed ff and given ample time ffered replacements for in, for 1 of 1 resident stance to dine in a sident #74).  cord was reviewed on m. rrent diagnoses included, ted, Alzheimer's disease  a current, 11/8/11, in Data Set assessment icated the resident istance in order to eat.  a current, 3/4/11, care d regarding nutritional imer's disease and the ied Approaches to this in, but were not limited to, sume 75% of meals; to consume meals.  11:40 a.m. to 12:35 observation, CNA #6 fed meal. While feeding CNA did not speak to	eat and was nutral adequately by sto eat, and was opoor consumption reviewed for assumple of 15 (R. Findings included Resident #74's roots 12/5/11 at 3:37 grand Resident #74's country but were not limit and anxiety.  Resident #74 has annual, Minimu (MDS) which in required staff as Resident #74 has plan problem/nerisk due to Alzh inability to self groblem included encourage to conallow ample time. During a 12/5/1 p.m., lunch mea Resident #74 hes Resident #74 hes Resident #74, the	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			JLTIPLE COI LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	155295	B. WIN			12/08/2011
NAME OF PROVIDER OR SUPPLIED		•	809 W F	DDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041	
PREFIX (EACH DEFICIENT TAG REGULATORY OF resident to eat, in praise the consumer to the praise the praise the consumer to the praise that t	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) nake conversation or mption of food. CNA #6 eadset the entire meal.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  meal times on randor shifts five times a	DATE
The CNA did not tapped the spoor encourage the re #74 ate very slow two glasses of cl stated to an unid "she likes to drin Resident #74 corbites and ate ver not speak to Resmove her tray of napkin.  During a 12/5/12 CNA #6 indicate feeding Residen slowed down an Following the in requested to con #74. Resident # approximately 2 bites, Resident # than 25% of her  During a 12/5/12 when questioned being offered for	on the resident's lip to sident to eat. Resident wly. Resident #74 drank nocolate milk. CNA #6 entified staff member ak." At 12:22 p.m., antinued to take very small y slowly. CNA #6 did ident #74 and began to aff the table and fold up the table and stopped to #74 because she had d wasn't eating much. terview, the CNA was tinue to feed Resident 74 ate an additional to bites. Following the 20 to 174 had still eaten less			week for one month, times a week for one month, once a week for one month, and monthly for 3 months. Staff non-compliance will be addressed with 1:1 education and progressive disciplinary action as deemed.  IV. Results who be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.	s. h
could not have a	use one did not come on	RLTV11	Facility II	D: 000192 If continuation s	heet Page 28 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
	155295			G		12/08/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
CLINTO	N HOUSE HEALTH	AND DELIAD CENTED			FREEMAN ST		
		AND REHAB CENTER			FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG		questioned if she should	+	IAG	,		DATE
	1	NA #6 again said she was					
	· · · · · · · · · · · · · · · · · · ·	now what to do. CNA #6					
		urse what should be done					
	regarding Reside						
	consumption.	211t # / 4 3 10 W					
	Consumption.						
	During a 12/5/1	1, 12:33 p.m., interview,					
	-	esidents have poor					
	consumption, the	-					
	_	some residents have a					
		ne refrigerator. She					
	1	ent #74 had a drink					
		ne refrigerator which					
		. When requested to offer					
		, LPN #7 offered Resident					
		pplement, Resource. The					
		nsumed 100% of the					
	supplement drin						
	The Property with						
	During an 12/5/3	11, 12:35 p.m., interview,					
	_	d CNA #6 should have					
	spoken to the res	sident and encouraged					
	_	dine. The CNA should					
		onversing with the					
		talked with the resident.					
	Review of a curr	rent, facility policy titled					
	"Eating Support	", which was provided by					
	the Director of N	Sursing on 12/8/11 at					
	12:48 p.m., indi	cated the following:					
	"Never make the	e resident feel that a meal					
	must be hurried,	but that the procedure is					
		nim/her your complete					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SU COMPLET 12/08/20	ГЕО
NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER			STREET 809 W	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST KFORT, IN46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F0328 SS=D	3.1-46(a)(1) 3.1-46(a)(2)  The facility must eproper treatment aspecial services: Injections; Parenteral and en Colostomy, ureten Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses. Based on record interview, the factoxygen was admordered rate for 3 with oxygen in a (Residents# 6, 28) Findings include  1. The record for reviewed on 12/5 Current diagnose limited to, Chrom Pulmonary Disease Current physician	postomy, or ileostomy care; e; g;  g;  review, observation and cility failed to ensure inistered at the physician 3 of 4 residents observed sample of 15.  g, and 43)  cor Resident # 6 was 5/11 at 3:30 p.m.  es included, but were not nic Obstructive ase.  In orders for December in order for oxygen to be	F0328	I. Residents # 6, 28 and 4 been assessed and found adverse affects have beer identified by this alleged d practice. II. Residents wh physician orders to have cadministered have the pot be affected by the alleged deficient practice. A review those residents who have orders has been conducte that any change of conditibeen reported to the physill. Nursing staff have been re-educated on facility expectations of following physicians' orders, adminitereatments and documents DON or designee will montreatment and O2 rates or random shifts 3 times a wone month, once a week f months, once a month for months. Staff non-complia	no eficient o have exygen ential to v of O2 d, and on has cian. en estering ation. itor eek for or two three	01/07/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155295		LDING	00	12/08/2	
		100200	B. WIN		DDDEGG CITY CTATE 7ID CODE	12/00/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER			FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, and the second	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	be addressed with 1:1 educa	ition	DATE
		p.m., Resident # 6 was r in the hallway; his			and progressive disciplinary	111011	
	oxygen rate was	• •			action as deemed. IV. Resul		
	oxygen rate was	set at 2.5 liters.			will be reviewed in QA meeting monthly x 6 months and ther		
	At 3:20 p m the	e resident was in his			quarterly with subsequent pla		
		s room; his oxygen rate			development and implement		
	was set at 2.5 lite				as appropriate.		
	At 3:25 p.m., LP	N # 2 was informed the					
	oxygen was set a	at the incorrect rate. At					
	that time, during	interview, she indicated					
	the resident should be on 2 liters of oxygen and she changed to flow rate to 2						
	liters.						
	2 The record fo	or Resident # 28 was					
	reviewed on 12/0						
		es included, but were not					
	limited to, Chron	-					
	Pulmonary Disea						
		n orders for December					
		n order for oxygen to be					
		maintain saturations					
	greater than 90 %	% and to keep at 2 liters.					
	On 12/5/11 at 5:	30 p.m., the resident was					
		r in the dining room. Her					
	oxygen rate was	set at 1.5 liters. At that					
	time, LPN # 3 cl	necked the flow rate and					
	1	interview, indicated the					
	flow rate should						
		was observed on					
	12/7/2011 at 9:1	5 A.M. She had oxygen					

	NT OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295		LDING	NSTRUCTION  00	(X3) DATE COMPI 12/08/2	LETED
NAME OF	PROVIDER OR SUPPLIE	R	-		DDRESS, CITY, STATE, ZIP CODE		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	infusing via a naset at 1 L. LPN said Resident #4 at 2L. She then setting to 2 L.  Resident #43's conceived on 12/ Resident #43's dolimited to, COP pulmonary disease hypertension, consumption aright hip fracture fixation.  The resident's Don's orders indicated originally dated at 2L/min per Normal A. A policy title Administration's Nurse Consultar The policy indicated Check physician method of administration of administrat	asal cannula. The rate was #1 observed the same and as should have her oxygen changed the oxygen changed the oxygen dinical record was 06/2011 at 1:15 P.M.  Itagnoses included, but not D (chronic obstructive ase), depression, bronary heart disease, and are with an internal december 2011 physician's the resident had an order 10/21/2011 for "Oxygen C (nasal cannula)."					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/08/2	ETED
	PROVIDER OR SUPPLIER	AND REHAB CENTER		809 W F	DDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041		
(X4) ID PREFIX TAG F0329	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)  ug regimen must be free		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
SS=D	from unnecessary drug is any drug we (including duplicate duration; or without without adequate in the presence of accordinate the dose is discontinued; or an reasons above.  Based on a comproper resident, the facility residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unle in an effort to disconstruction of the disco	drugs. An unnecessary when used in excessive dose therapy); or for excessive at adequate monitoring; or indications for its use; or in diverse consequences which should be reduced or my combinations of the rehensive assessment of a y must ensure that the not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and antipsychotic drugs receive ctions, and behavioral is clinically contraindicated, continue these drugs. It is continue the drugs in the drugs	F0	329	I. Residents # 6, 44 and 49 have been assesse by the nursing staff and change of condition was reported to the Primary Care Physician.  II. Residents who have	d	01/07/2012

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
CLINTON	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	Findings include	:			diagnosis of psychot	ic
	1. Resident #49 <sup>t</sup> 12/7/11 at 2:00 p	s record was reviewed on o.m.			behaviors and are treated with	
		urrent diagnoses included, ited, Tourettes syndrome th behavioral			antipsychotic medications have th potential to be affected by this	e
		d a current order, which /10, for resident may be rist.			alleged deficient practice. Those residents who	
	quarterly, Minim (MDS) which in	d a current, 10/25/11, num Data Set assessment dicated the resident was aladaptive behaviors sment period.			currently receive antipsychotic drugs have been reviewed for behavior	
	progress note wh	d a 7/13/11, psychiatry nich indicated the edication, Haldol, would			monitoring and the necessity of antipsychotic drug use. Nursing staff ar	nd
	progress note whe following: "SSD [social seresed] agitate yell @ peers whe anxious & can be	d an 11/16/11 psychiatry nich indicated the vice director] reports tion/angers easily, will en upset. He will look e intrusiveno overt o risk for self harm			Social Service department have be re-educated on the "Behavior Monitorin Program", and use of antipsychotic drugs,	en Ig
FORM CMS-2		s indicated at this time	RLTV11	Facility I		sheet Page 34 of 54

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPLI	
		155295	A. BUII B. WIN	LDING G		12/08/20	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CLINTON	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	D/C [discontinue	LSC IDENTIFYING INFORMATION)		TAG			DATE
	-	[increase] Depakote [ an			assessments,		
		ication used as a mood			interventions and		
	stabilizer]"				documentation.		
	   Resident #49's "I	Behavior/Intervention			III.		
		ecord" for November and			Social Service/DON		
	`	ough 7) 2011 were			will audit for new		
		ent #49 was being rbal aggression, physical			antipsychotic drug us	e	
		nxiety. Resident #49			each morning in		
		ode of physical aggression			clinical meeting 5		
		y period. Resident #49			times a week. Social		
	_	f verbal aggression period. The clinical			Service will randomly	,	
	record lacked an	_			audit behavior		
	" "	bal aggression having					
		ted the resident's quality lity of life of others.			monitoring		
	of fife of the qua	itty of the of others.			documentation,		
	Resident #49 had	l a 12/5/11, 12:00 p.m.,			assessment and		
		ote which indicated,			interventions 5 times	a	
		he dining room, Resident peer on the arm. A nurse			week for one month,	3	
		ve the resident from the			times a week for the		
		with him in the hall.			following month,		
		utes res [resident] was			weekly for the next		
		d to dining room. Res			four months. Staff		
					non-compliance will		
		l a 12/5/11, 12:45 p.m.,			be addressed with 1:	1	
	1 ^ *	for Haldol 6.5 mg			education and	•	
		edication) two times was obtained from the			Education and		

000192

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	LDING	NSTRUCTION  00	(X3) DATE : COMPL 12/08/2	ETED
	PROVIDER OR SUPPLIER	AND REHAB CENTER	STREET A	DDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	resident's primar	y physician.		progressive		
	The clinical reco	rd lacked:		disciplinary action as		
	b.) An assessmer factors to the behrestarting an anti- c.) Indication the monitory psycholoehavioral sympolecision making the, 12/5/11, behresident calmed of During an 12/7/1 the Director of Noresident had a unform of assessment behavior outburs resident calmed of the event. She in not wait for the robefore re-starting medication. She was not involved re-start Resident	assessment of the g his refusal post event.  It of possible contributing havioral outburst prior to psychotic medication.  It psychiatrist, who was active medications and toms, was involved in the for treatment following avioral outburst when the quickly thereafter.  It, 4:00 p.m., interview fursing indicated the ine culture and no other ent after the 12/5/11 tt. She indicated the very quickly following adicated the facility did esults of urinary culture g the antipsychotic indicated the psychiatrist at the decision to		IV. Results will be reviewed in QA meeting monthly x 6 months and then quarterly with subsequent plan development and implementation as appropriate.		
	reviewed on 12/6	5/2011 at 12:43 P.M.				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			LDING	NSTRUCTION  00	(X3) DATE COMPL 12/08/2	ETED	
NAME OF I	DROVIDED OD SUDDI IED		p. ,, 1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	(			FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		FRANK	FORT, IN46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
	Resident #44's d	iagnoses included, but					
		to, acute respiratory					
	failure, pneumonia, hypokalemia, malnutrition, hypertension, and dementia.						
	mamurition, hypertension, and dementia.						
	Resident #44's December 2011						
		rs indicated an order					
		11/25/11 for olanzapine					
	(Zyprexa) (antipsychotic) 5 mg						
	(milligram) give 1 tablet once a day."						
	(immigram) give i tablet once a day.						
	The November 2	2011 behavior					
	documentation a	and December 2011					
	behavior docume	entation was reviewed for					
	documented beha	aviors. This					
	documentation la	acked any monitoring of					
	behaviors.						
	During an interv	iew with LPN #12 on					
		14 P.M., she indicated					
	there was no doc	rumentation of the					
	-	ere should have been.					
		ated there was no care					
	plan related to th	e use of the olanzapine.					
	,						
		iagnoses did not have a					
	_	gnosis for the use of the					
	_	ing an interview with the					
		011 at 3:30 P.M., she					
		ident had a diagnosis for					
		nnzapine when she was a					
		time she was here, but it					
	had not been car	ried over onto this chart.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  A. BUILDING (12/08/2011)			ETED	
		155295	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/08/20	)
NAME OF I	PROVIDER OR SUPPLIER	2			FREEMAN ST		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER		FRANK	FORT, IN46041		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	3. The record for R 12/5/11 at 3:30 p.m	esident # 6 was reviewed on .	FO	329	I.		01/07/2012
	Current diagnoses i	ncluded, but were not limited			Residents # 6, 44 and		
	to, dementia.	neradod, out were not infinted			49 have been assesse	ed	
	Current physician o	rders for December 2011			by the nursing staff		
		for Xanax 0.25 milligrams fly as needed for agitation.			and change of		
	Original date of order was 10/10/11.				condition was		
	The October Medic	ation Administration Record			reported to the		
	for October 2011 indicated the resident was given Xanax 0.25 milligrams on 10/10, 11, 12, 13, 14,				Primary Care		
15, 18, 29, and 31, 2011. No indicate				Physician.			
	was identified.				II.		
		tion was requested on 12/6/11			Residents who have		
	_	he Director of Nursing rventions and behaviors for the			diagnosis of psychotic	C	
	use of the Xanax.				behaviors and are		
		a.m., the Director of Nursing			treated with		
		no behaviors or prior e use of the Xanax. She			antipsychotic		
	indicated the Xanax "sleeper."	was being given for a			medications have the	)	
					potential to be		
		Psychoactive Medication provided by the Nurse			affected by this		
		11 at 9 a.m., and deemed as indicated: "Policy It is the			alleged deficient		
	policy of this facilit	y that residents in need of			practice. Those		
	psychotherapeutic medications receive appropriate assessment and interventions in order to achieve their highest practicable level of functioning, that residents with mental illness receive the necessary				residents who		
					currently receive		
	treatment to enable	or restore their			antipsychotic drugs		
	function,Procedure3. When psychoactive medications are prescribed for a specific condition				have been reviewed		
		·					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/08/2011
		AND REHAB CENTER	809 W F	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041	(X5)
PREFIX TAG	(EACH DEFICIEN REGULATORY OR or targeted behavior	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) , the clinical record will be	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPED DEFICIENCY)  for behavior	COMPLETION
	have a care plan in pronon-drug interventical leviate the conditions and nor regularly documents notesPsychoactive PRN (as needed) bactlear and specific in attention should be approaches outlined to using a PRN med promote sleep8. Monitored and documents and documents and documents are promoted and documents are promoted and documents and docum	drugs may be ordered on a sis and should have a very dications for use. Special given to attempt non-drug in residents' plan of care prior ication to control behavior or Medication effects will be mented on the medication d, to include targeted behavior nitoring for adverse effects		monitoring and the necessity of antipsychotic drug use. Nursing staff a Social Service department have be re-educated on the "Behavior Monitorin Program", and use of antipsychotic drugs, assessments, interventions and documentation.	een ng of
				Social Service/DON will audit for new antipsychotic drug u each morning in clinical meeting 5 times a week. Social Service will random audit behavior monitoring	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			LDING	NSTRUCTION  00	(X3) DATE COMPL 12/08/2	ETED	
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
CLINTON	HOUSE HEALTH	AND REHAB CENTER		FRANKI	FORT, IN46041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
					documentation,		
					assessment and		
					interventions 5 times	a	
					week for one month,	3	
					times a week for the		
					following month,		
					weekly for the next		
					four months. Staff		
					non-compliance will		
					be addressed with 1:	1	
					education and		
					progressive		
					disciplinary action as		
					deemed.		
					IV.		
					Results will be		
					reviewed in QA		
					meeting monthly x 6		
					months and then		
					quarterly with		
					subsequent plan		
					development and		
					implementation as		
					appropriate.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/08/2011
	PROVIDER OR SUPPLIER	AND REHAB CENTER	809 W	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST (FORT, IN46041	
(X4) ID PREFIX TAG F0425 SS=E	(EACH DEFICIENG REGULATORY OR The facility must pemergency drugs	and biologicals to its	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	described in §483. facility may permit administer drugs if under the general nurse.  A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed phanconsultation on all pharmacy services Based on observatinterview, the fact and destroy expiritivials of insulin of 1 of 1 resident in 3 residents in a straightful as with expired in #18, and #27).  Findings included 1. During the met 12/05/2011 at 11 the following was medication room Resident #18 had	mploy or obtain the services macist who provides aspects of the provision of in the facility.  ation, record review and cility failed to remove red insulin for 4 of 22 bserved which impacted a sample of 15 and 3 of applemental sample of nsulin (Residents #3, #4,  d:  d:  edication observation on :10 A.M. with LPN #14, is observed in the	F0425	I. Residents # 3, 4, 18 and 27 were assessed for any adverse affect from alleged deficien practice with any findings reported to the physician. II. Resident with the diagnosis of Diabetes have the potential to be affected by the alleger	ts t nts

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMP 12/08/2	LETED
	PROVIDER OR SUPPLIER	AND REHAB CENTER	<u> </u>	809 W F	DDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN46041	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	insulin dated with of 11/29/2011. Resident #3 had insulin dated with of 12/02/2011. Resident #4 had open date of 10/2 LPN #14 indicate where in use, but needed to be des 4 new bottles of residents.  Review of the post for "Maximum Serial Insulin Vials" proconsultant on 12 indicated all vial were expired after the serial street with the serial street in use.	ed the 4 bottles of insulin they were outdated and troyed. She then retrieved			deficient practice. A audit of the medication carts was conducted. Nursing staff have been re-educated on the policy and procedur of medications and expiration dates.  III. DON of designee will monitiall medication carts expired meds 5 times a week for one more 3 times a week for one month, once a week for one month, there monthly for 3 months Staff non-compliant will be addressed will be addressed will education and progressive disciplinary action and deemed.	r or for es oth, one of hs. ce ith	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295		(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/08/2011	
		133233	B. WING	ADDRESS, CITY, STATE, ZIP CODE	12/00/2011
NAME OF P	PROVIDER OR SUPPLIER	8		FREEMAN ST	
CLINTON	N HOUSE HEALTH	AND REHAB CENTER	FRANK	FORT, IN46041	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION DATE
				IV. Results	will
				be reviewed in QA	
				meeting monthly x	6
				months and then	
				quarterly with	
				subsequent plan	
				development and	
				implementation as	
				appropriate.	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  12/08/2011
			B. WING	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			FREEMAN ST	
CLINTON	N HOUSE HEALTH	AND REHAB CENTER		FORT, IN46041	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0441 SS=F	Infection Control F a safe, sanitary an and to help prever	stablish and maintain an Program designed to provide ad comfortable environment at the development and sease and infection.			
	Program under wh (1) Investigates, co- infections in the fa (2) Decides what p isolation, should b resident; and (3) Maintains a rec	stablish an Infection Control nich it - ontrols, and prevents			
	determines that a prevent the spread must isolate the re (2) The facility must communicable dis lesions from direct their food, if direct disease.  (3) The facility must hands after each communication of the facility must hands after each communication of the facility must hands after each communication.	ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted			
	transport linens so infection.  A. Based on reco the facility failed infection control tracking, trending	andle, store, process and of as to prevent the spread of ord review and interview, to implement an program which included g, and follow up infectious patterns. This	F0441	I. No negative outcome	01/07/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155295 12/08/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 809 W FREEMAN ST CLINTON HOUSE HEALTH AND REHAB CENTER FRANKFORT, IN46041 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE deficient practice had the potential to was identified impact 73 of 73 residents. through observation or assessment for B. Based on observations, interview, and record review, the facility failed to ensure the alleged deficient infection control practices were practice. implemented and followed in a manner to Ш. ΑII prevent the potential for the spread of residents have the infections and diseases during personal care for 1 of 2 residents observed for potential to be personal care in a sample of 15 (Resident affected by the # 18) (CNA # 4), and failed to ensure alleged deficient isolation procedures were implemented for 1 of 1 resident reviewed for isolation practice. A review of in a sample of 15 (Resident #43), and those residents failed to ensure handwashing in the dining currently being room was completed when indicated for 4 treated for an of 4 residents reviewed in a supplemental sample of 13. (Resident #48, 58, 16, and infection and no 45) (CNA # 8, 9, and 10) trends were identified. Nursing Findings include: staff has been A1. On 12/6/11 at 3 p.m., the Director of re-educated on the Nursing provided the infection control Infection control program, including her tracking and trending, and this information was policy, hand reviewed at this time. The information washing, isolation included a laboratory print out of residents procedures, with urinary tract infections and bowel transporting linens, infections. Facility layouts were provided for July, August, September, October and ice passing. November 2011 with room numbers DON/ADON has highlighted to indicate rooms with urinary

RLTV11

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	LDING	NSTRUCTION 00	l í	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER N HOUSE HEALTH	AND REHAB CENTER	809 W F	ADDRESS, CITY, STATE, ZIP FREEMAN ST FORT, IN46041	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	At 3:45 p.m., dur Director of Nurs provided all the information she indicated there we the building duri At this time, she pharmacy print of the last 3 months.  On 12/7/11 at 4 p was provided for during the above out indicated the prescribed antibir respiratory, pneudellulitis and wo infections were nor tracked and tracked and tracked in the contamination of the c	had. When queried, she were no other infections in ing the above time frame. was asked to supply a put of all antibiotics for it.  p.m. a pharmacy print out all antibiotic therapies it time frame. The print is ever experience of the print in the print in the were 22 residents of the print in the print i		designee will randomly Ha washing, Ice linen transport for one mont times a week month, week one month, week one monthly for 3 months. DON monitor track trending week Staff non-compliant be addressed 1:1 education progressive disciplinary a deemed.	trend all per son or lamonitor and pass, ort daily the son one sly for and then son or lambda will a with an and	

NAME OF PROVIDER OR SUPPLIER CLINTON HOUSE HEALTH AND REHAB CENTER  SYMPHONE HEALTH AND REHAB CENTER  SIMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG  Policies" was provided by the Director of Nursing on 12/6/11 at 3 p.m., and deemed as current. The policy indicated: "Infection surveillance will be either "whole house" or "targeted" toward high risk/high volume, whichever is in accordance with local and state department of health requirements"  B.1. During a personal care observation on 12/5/11 at 4.45 p.m., with Resident # 18, CNA # 4 with gloved hands applied Calazime ointment to the resident's coccyx and gluteslas, then removed her gloves and washed her hands for less than 8 seconds. She domined gloves and assisted CNA # 13 to transfer the resident into her wheelchair. CNA # 4 then removed her gloves and washed her hands for less than 5 seconds and removed the resident's oxygen tubing from the concentrator and placed it onto the portable tank. B. 2. During the facility four on 12/05/2011 at 10:05 A.M., Resident #43 was identified by LPN #1 as being on an antibiotic. There were no signs on the door nor was there any personal protective equipment outside or inside the room.  On 12/06/2011 at 10:30 A.M., there were no signs on the door nor was there any personal protective equipment outside or inside the room.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			LDING	00		) DATE SURVEY COMPLETED 2/08/2011	
REFIX TAO REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAO REGULATORY OR LSC IDENTIFYING INFORMATION)  PROBLEMS TAO  REGULATORY OR LSC IDENTIFYING INFORMATION)  PROBLEMS TAO  Nursing on 12/6/11 at 3 p.m., and deemed as current. The policy indicated:  "Infection surveillance will be either "whole house" or "targeted" toward high risk/high volume, whichever is in accordance with local and state department of health requirements"  B.1. During a personal care observation on 12/5/11 at 4:45 p.m., with Resident # 18, CNA # 4 with gloved hands applied Calazime ointment to the resident's coocyx and gluteals, then removed her gloves and washed her hands for less than 8 seconds. She donned gloves and assisted CNA # 13 to transfer the resident into her wheelchair. CNA # 4 then removed her gloves and washed her hands for less than 5 seconds and removed the resident's oxygen tubing from the concentrator and placed it onto the portable tank.  B. 2. During the facility tour on 12/05/2011 at 10:05 A.M., Resident #43 was identified by LPN #1 as being on an antibiotic. There were no signs on the door nor was there any personal protective equipment outside or inside the room.  On 12/06/2011 at 10:30 A.M., there were no signs on the door nor was there any personal protective equipment outside or inside the room.				<i>p.</i> w	STREET A	REEMAN ST	IP CODE	
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		Policies" was pro Nursing on 12/6/as current. The promote in the p	ovided by the Director of 11 at 3 p.m., and deemed policy indicated: eillance will be either or "targeted" toward high toward care observation toward policy and to the resident's als, then removed her toward her toward her hands for less than donned gloves and toward toward toward high toward washed her hands conds and removed the trubing from the placed it onto the facility tour on toward high toward has being on an toward high towar			QA meeting x 6 months quarterly wisubsequent development appropriate	g monthly and ther ith t plan nt and ation as	

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295		ILDING	NSTRUCTION  00		(X3) DATE ( COMPL 12/08/2	ETED
NAME OF F	DDOMNED OD GIDDI 151		B. WII		DDRESS, CITY, STA	ATE, ZIP CODE		
	PROVIDER OR SUPPLIEI				REEMAN ST			
		I AND REHAB CENTER		<u> </u>	FORT, IN46041			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		LAN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)		TAG		ED TO THE APPROPRIAT ICIENCY)	Ē	DATE
IAU	On 12/07/2011 a sign on the door was on contact propersonal proper	at 9:15 A.M., there was a indicating the resident orecautions, but there was attective equipment outside om.  Clinical record was 106/2011 at 1:15 P.M.  Cliagnoses included, but not D (chronic obstructive ase),, depression, oronary heart disease, and are with an internal as readmitted to the 10/2011 at 6:30 P.M.  Curses' notes indicated: 5 P.M., " Bowels al smelling. MD made er check for C-Diff" 10 P.M. "N.O. rec'd lagyl (an antibiotic) mg. D. (by mouth) BID X 14"  A.M. " Universal tinue. loose stool x 1 this obysician's orders		IAU				DATE
		3011 "Flagyl 500 mg.						
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete Event ID:	RLTV11	Facility I	D: 000192	If continuation sh	eet Pad	ge 48 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155295	B. WIN			12/08/2	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER			FREEMAN ST FORT, IN46041		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
		ne) PO (by mouth) BID					
	(2 times a day) x 14 days. Then re-check stool for C. Diff.						
	Stool for C. Diff.						
	During an interv	iow with I DN #1 on					
	During an interview with LPN #1 on 12/06/2011 at 2:30 P.M., she indicated the						
	facility was using universal precautions						
		C.diff infection.					
	During an interv	iew with the Nurse					
	Consultant on 12/7/2011 at 9:20 A.M.,						
	she indicated the resident should have						
	been in contact isolation and there should						
	have been a sign	on the door.					
	B. 3. During the	e noon meal observation					
	on 12/05/2011 s	tarting at 11:40 A.M., the					
	following was o	bserved:					
	11:47 A.M., CN	A #8, removed the ice					
	scoop, which wa	s submerged in the ice					
	bucket to include	e the handle, from the ice					
		ped the ice into the glass,					
		er, and took the water to					
	a resident.						
		A # 9 removed the ice					
	1 '	s submerged in ice, from					
		nd scooped the ice into					
		t with water, and took the					
	water to a reside						
		A #10 picked up a fork					
		hich Resident #48 had					
		loor. She took the fork					
		en and returned with a set					
	of silverware an	d handed them to					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155295			LDING	NSTRUCTION  00		e survey Pleted '2011		
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  809 W FREEMAN ST  FRANKFORT, IN46041					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	the kitchen and g #58 and then too resident. She op knife, and butter resident. She the the resident. She window for food food to Resident silverware, butte the silverware, p lap, pushed her v CNA #10 returne removed the scoo container, filled the ice scoop to t with water. She Resident #45. Si food out of the d room. She return and used alcohol 12:15 P.M. CNA scoop, which wa the ice container ice, returned the container, filled took it to a reside  During an interv Administrator or he indicated the	ened the butter, took the ed the bread for the en gave the silverware to e returned to the kitchen. She took the plate of #16. She took the red her bread, gave her laced her napkin in her wheelchair up to the table. Ed to the ice container, op from inside the ice a glass with ice, returned the container, and filled it took the glass of water to me then took a tray of ining room to a resident's ned to the dining room gel before her next task. #11 removed the ice is submerged in ice, from a filled a glass with the scoop to the ice the glass with water and ent.						

NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  B. 4. Review of the policy for undated isolation policy provided by the Nurse Consultant on 12/7/2011 at 9:00 A.M., indicated "It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions. The 1996 Center for Disease Control Guidelines for isolation	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155295			MULTIPLE CO JILDING ING	NSTRUCTION  00		(X3) DATE COMPL 12/08/2	ETED			
CLINTON HOUSE HEALTH AND REHAB CENTER  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  TAG  B. 4. Review of the policy for undated isolation policy provided by the Nurse  Consultant on 12/7/2011 at 9:00 A.M., indicated "It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions. The 1996 Center for Disease  809 W FREEMAN ST  FRANKFORT, IN46041  ID  PROVIDERS PLAN OF CORRECTION  (EACH OEORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  OMPLETION  TAG  PREFIX  TAG  COMPLETION  DATE  (X5)  COMPLETION  DATE	NAME OF DROVIDER OR SLIDDI IED										
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isolation policy provided by the Nurse Consultant on 12/7/2011 at 9:00 A.M., indicated "It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions. The 1996 Center for Disease				<i>'</i>							
Consultant on 12/7/2011 at 9:00 A.M., indicated "It is the policy of this facility to prevent the spread of infection within the facility through the use of isolation precautions. The 1996 Center for Disease											
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prevent the spread of infection within the facility through the use of isolation precautions. The 1996 Center for Disease											
facility through the use of isolation precautions. The 1996 Center for Disease											
		facility through t	the use of isolation								
		precautions. The	e 1996 Center for Disease								
		_									
Precautions will be utilized in this		Precautions will	be utilized in this								
facility Procedure for Isolation 3.		facility Proceed	dure for Isolation 3.								
Contact Precautions: In addition to											
Standard Precautions, use Contact		Standard Precautions, use Contact									
Precautions for residents known or		Precautions for residents known or									
suspected to be infected with		suspected to be infected with									
microorganisms that can be easily		microorganisms that can be easily									
transmitted by direct or indirect contact,		transmitted by direct or indirect contact,									
such as handling environmental surfaces		such as handling environmental surfaces									
or resident -care itemsnoncompliant			•								
behaviors with stool resident has very		behaviors with s	stool resident has very								
poor personal hygiene Clostridium			•								
difficile A. Obtain table/cart for 24		difficile A. Ob	btain table/cart for 24								
hour supply of masks, gowns, etc. needed			-								
to maintain isolation B. Obtain											
appropriate signage and post outside the			• •								
door frame Handwashing it the single											
most important precaution to prevent the			•								
transmission of infection from one person			infection from one person								
to another"		to another"									
D. 5. Deview of the undeted nelicy for		D 5 Desis - C	the undetect well fer								
B. 5. Review of the undated policy for											
provided on 12/08/2011 at 4:00 P.M., by		"Hand Hygiene Process Measures"									
the DON. The policy indicated "Health		*	, ,								
care workers, visitors and volunteers must		-	-								
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RLTV11 Facility ID: 000192 If continuation sheet Page 51 of 54	FORM CMS 2				4 Facility	D: 000400	If continuation ch	aat D-	no 51 of 54		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155295	A. BUILDING 00		COMPLETED			
133293			B. WINC			12/08/20	)	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
CLINTON HOUSE HEALTH AND REHAB CENTER					FORT, IN46041			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
		with soap and water:						
	•	er using the bathroom,						
	_	ed with dirt, after						
	` ` `	loved and damaged						
	,	vith blood, other body						
	·	, excretions, mucous						
	·	intact skin, intact skin						
		l and other body fluids,						
	_	and soiled dressings, after						
		ct and non-intact skin,						
	_	ironmental surfaces or						
		w onset diarrhea even if						
	_	. When forearms have						
		et (turning, lifting,						
		th the resident's skin, bed						
	clothes, etc.)  3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(j) 3.1-18(l)							
F0465		rovide a safe, functional,						
SS=C	residents, staff and	fortable environment for						
	· ·	ation and interview, the	F04	465	I		01/07/2012	
		ensure a soiled utility			l.		-	
	_	for 1 of 3 soiled utility			No negative outcome			
		and failed to ensure 2 of			was identified throug	h		
		closets were clean. This			•			
		e had the potential to			observation or			
		esidents who reside in the			assessment for the			
	building.				alleged deficient			
	S							
	Findings include				practice.			

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/08/2011	
NAME OF PROVIDER OR SUPPLIER  CLINTON HOUSE HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  809 W FREEMAN ST FRANKFORT, IN46041				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	12/07/11 at 1 p.m. Director and the Director the follow The soiled utility had 2 sets of bed air mattress, and floor.  In the activity ro had boxes, totes on the floor and scattered on the source of	y, during the tour, the pervisor indicated the			II.  All residents have the potential to be affected by the allege deficient practice. All areas identified have been assessed and cleaned or repaired by the housekeeping and maintenance staff.  III.  Maintenance and housekeeping will audit the building randomly three time a week for one month once a week for 3 months and monthly for 2 months to ensure proper cleaning and maintenance techniques have been established. Staff non-compliance will	ed y d	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 12/08/2011				
NAME OF P	ROVIDER OR SUPPLIER	· {		STREET ADDRESS, CITY, STATE, ZIP CODE					
CLINTON HOUSE HEALTH AND REHAB CENTER			809 W FREEMAN ST FRANKFORT, IN46041						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE				
				be addressed with 1	1				
				education and					
				progressive					
				disciplinary action as	;				
				deemed.					
				IV.					
				Results will be					
				reviewed in QA					
				meeting monthly x 6					
				months and then					
				quarterly with					
				subsequent plan					
				development and					
				implementation as					
				appropriate.					